The Bulletin

75th Division (Training Support)

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What's Inside

New Pay Chart Out

The 2000 Pay Charts are available in the February 2000 issue of Soldiers Magazine or online at www.dfas.mil/ . The new paychart reflects the 4.8% pay raise.

Choose or Lose!

For those who haven't noticed yet, 2000 is a Presidential Election year. Remember you have to register in order to vote. Registration is painless and easy, just contact the voter registration office in your area for more information. Voting is your right, exercise it. If you don't choose, you'll lose.

Van Kleeck Awarded One Star

Story and Photo by SGT Susan Reilly

HOUSTON --COL David A. Van Kleeck was promoted to the rank of Brigadier General during a ceremony on December 11, 1999 at the SGM Macario Garcia U.S. Army Reserve Center, headquarters of the 75th Division (TS).

MG Darrell W. McDaniel, commander of the 75th Division awarded Van Kleeck his first star with the assistance of Van Kleeck's wife Marilyn. Also in attendance were the couple's two sons, Michael and Brian, as well as Van Kleeck's mother and father who is a retired Navy Captain.

BG Van Kleeck began his miliatry career in 1973 after receiving his commission through ROTC upon his graduation from Princeton with a B.S. degree in engineering. Van Kleeck later went on to earn a PH.D in chemical engineering from Rice Universtity in Houston, TX. He was on active duty for four years before joing the Reserves.

In 1985, Van Kleeck assisted in the activation of the 450th Chemical Battalion, Houston, TX. He went on to command the 450th from November 1988 unitl September 1992 when he was assigned as the Assistant Deputy Chief of Staff for Training at the 90th U.S. Army Reserve Command in San Antonio, TX.

Van Kleeck commanded the Battle Projection Group, 1st Brigade, 75th Division (Exercise) from April 1994 through June 1996, when he took the position of Chief of Staff for the 75th Division. BG Van Kleeck's current assignment is that of Assistant Division Commander, 75th Division (TS) and Commander, 1st Brigade (BCST), 75th Division.

Throughout his military career, Van Kleeck has recieved numerous citations and awards, including the Legion of Merit, Meritorious Service Medal (w/4 Oak Leaf Clusters), Army Commendation Medal (w/2 Oak Leaf Clusters), Army Achievement Medal, Army Reserve Component Achievement Medal (w/Silver Oak Leaf Cluster), Armed Forces Reserve Medal (w/ Silver Hour Glass) and the Parachutist Badge.

The National Defense Authorization Act For 2000

What Does It Mean for you?

President Clinton's signature on the $289 billion fiscal year 2000 National Defense Authorization Act (NDAA), which was signed into law Oct. 5, 1999, will significantly benefit the nearly 1.4 million members of the National Guard and Reserve.

Beginning Jan. 1, 2000, Reserve component personnel will see a 4.8% increase in their drill and annual training pay. The pay raise is the highest in a generation. In addition,

See NDAA Page 2

1st SEG Food Drive Helps Feed Houston's Hungry

Story by SSG Barbara Spruill, Photo by SGT Susan Reilly

The 1st Simulation Exercise Group conducted a Food Drive for the 1999 Christmas Holiday Season. SSG Barbara Spruill, 1st SEG PSNCO along with SSG Rosa Hinojosa orchestrated a food drive in an effort to feed 10 families in the Houston area for the Christmas season. SSG Spruill started collecting non-perishable food items from the members of the 1st SEG in OCT and also collected monetary donations. COL Price, the 1st SEG Commander and CPT D'Costa, the HHD Commander, supported the Food Drive by challenging other officers to match their donations. The combined efforts of the 1st Simulation Exercise Group resulted in SSG Spruill and SSG Hinojosa being able to donate 20 complete dinners to include turkeys to three Houston communicty organizations, The Star of Hope, The Women's Center of Houston and A Changing World Center for Boys. These organizations were chosen by suggestions from members of the 1st SEG and 1st BDE.

NDAA *continued*

the NDAA provides for targeted pay increases in basic pay upt to 5.5% effective July 1, 2000.

Selected highlights of other provisions of the NDAA legislation:

* Increases the Selected Reserve enlistment bonus from $5,000 to $8,000 for those who enlist in the Selected Reserve. The law also extended from 1.2/31/99 to 12/31/2000 certain bonuses and special pay authorities for Reserve forces.

* Authorizes Service Secretaries to offer a bonus to a member of the Selected Reserve with prior service experience who has completed the necessary training to qualify in a critically short wartime skill.

* Permits federal civilian employees to also use their military leave to perform drills or inactive duty training (IDT).
Extends to Jan. 1, 2001, the authority for repayment of education loans for certain health professionals who serve in the Selected Reserve.

*Authorizes special pay for members of the Coast Guard Reserve assigned to high priority units of the Selected Reserve at the rate of $10 per drill period.

* Authorizes the Secretary of Defense to waive the TRICARE deductible for Reserve component members on active duty pursuant to a call or order to active duty for less than one year in support of a contingency operation.

* Permanently extends the "forgotten widow" annuity, which pays $1.65 per month to certain widows of deceased gray-area retirees.

* Allows chaplains in the Reserve components of the Army and Air Force to be retained until age 67. Chaplains in the Naval Reserve could already be retained until age 67.

*Authorizes the Chainnan of the Joint Chiefs of Staff (CJCS) to designate up to 10 general/flag officer (GO/FO) positions on CINC staffs to be held only by Reserve component officers in the grade of 08 or 07. They do not count against limitations of GO/FO on active duty for more than 180 days,

* Expands the duties authorized for Active Guard and Reserve (AGR) personnel to include: (1) supporting missions or operations assigned in whole or part to the Reserve components; (2) supporting missions or operations perforrned by a multi-component or joint forces unit; (3) advising the Secretary of Defense, Military Department secretaries, Joint Chiefs of Staff and CINCs on Reserve component matters. This change provides the Reserve components with greater flexibility to employ all available manpower, both full-time and part-time, to accomplish assign.

*Authorizes about $2 billion for National Guard and Reserve equipment, including the President's budget and congressional adds.

The Bulletin is an authorized unofficial publication of the 75th Division (Exercise) that is published quarterly by the 75th Division (Exercise) under provisions of AR 360-81. Stories, letters to the editor, photographs with complete captions are invited and may be sent to the editor at the 75th Division, 1850 Old Spanish Trail, Houston, TX 77054. Phone: 713-799-7591. Email: hrmcneely@yahoo.com. The editor reserves the right to edit or reject submissions. The views and opinions expressed in this publication are not necessarily those of the Dept. of the Army.

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From the Division Surgeon:

Improving Reserve Health Care

BACKGROUND

Current legislation and policy reflect the historic use of reservists by structuring medical and dental care, incapacitation, and disability entitlements according to length of assignment: 30 days or less or more than 30 days. However, it is the performance of duty, not the length of duty that creates the risk for harm. Reservists now work side by side with AC members and perform the same missions as AC members. Yet, when a reservist is injured performing one of those missions, entitlement to health care, pay, and family support is different from that of the AC member. RC benefits currently are based on the length of duty rather than the performance of duty. The increased exposure to risk associated with increased reliance on the RC has resulted in an increasing number of line of duty injuries to reservists and has served to highlight the disparity between Active and Reserve component medical benefits and entitlements, despite exposure to similar levels of risk. There is currently no uniform, DOD-wide rule on accountability and responsibility for providing health care services to RC members, creating a risk of inconsistent treatment of similarly situated individuals.

Correction of an Inequity

Both the Department and Congress recognized the potential for inequities in the coverage provided members on active duty for 30 days or less vice those serving 31 days or more. In the National Defense Authorization Act for FY 1998, medical coverage provided in section 1074a was expanded for members serving on active duty for 30 days or less, whose orders are modified or extended so as to result in active duty of more than 30 days. In such cases, the member is now entitled to medical and dental care on the same basis and to the same extent as members covered under section 1074 (Active component members).

This change applies to Reserve component members who are being treated for or recovering from an injury, illness or disease incurred or aggravated in the line of duty, while performing active duty for a period of 30 days or less. In addition, the dependents of a member whose orders are extended are entitled to medical and dental care provided under section 1076 while the member remains on active duty. This important change in Reserve component benefit it protections does not address members who sustain a disabling injury or disease while performing inactive duty training.

Inactive Duty Training

Inactive duty training is defined in DOD regulations as “authorized training performed by members of a Reserve component not on active duty, and performed in connection with the prescribed activities of the Reserve component of which they are a member.” It consists of regularly scheduled unit training periods, additional training periods and equivalent training. While the primary purpose is to provide individual and unit readiness training, it may also support Active component mission requirements concurrent with the performance of training.

This expanded use of inactive duty training provides increased flexibility for employment of Reserve forces in support of Total Force missions. It also creates the potential for a member in an inactive duty training status to serve alongside a member on active duty. In the event of serious injury, the difference in medical entitlements during the period of treatment and recovery for or the two categories of members and their dependents, based on the member’s respective duty status, becomes readily apparent. The member on inactive duty for training has no orders that can be extended or modified to entitle the member to the same care and benefits as a similarly affected Reserve component member on active duty. This also has a significant effect on the member’s dependents. Specifically, the member in the inactive duty training status is not eligible for health care for conditions other than the injury incurred in a duty status, and the dependents of the member are not entitled to health care in the military health system.

The dependents of a Reserve component member who dies from an injury, illness or disease incurred or aggravated while performing inactive duty training are entitled to continuing medical and dental care. However, the dependents of a member being treated for or recovering from a life threatening or other serious disability as a result of inactive duty training would not be entitled to medical or dental care under the military healthcare system.

Health Care Protection Under USERRA

A Reserve component member does have the option of continuing health coverage under his or her civilian employer-sponsored plan. The Uniformed Services Employment and Reemployment Rights Act (USERRA) enacted in 1994, now chapter 43 of title 38, U.S.C., provides for full health benefit continuation for persons who are absent from work to serve in the military. Health insurance coverage may be continued for the member and his or her dependents for up to 18 months during periods of military service. For a member who is ordered to active duty for 30 days or less, the employer may require the member to pay only his normal employee share. However, for or longer tours, the Reserve employee may be required to pay the full premium cost. If the employer requires the Reservist employee to pay most or all of the premium cost, this may discourage the Reservist from remaining in the employer-sponsored health care plan.

If a member chooses not to continue his or her civilian health coverage during the period of military service, the

(Editor’s Note: Because of the importance in the changes to Reserve Health Care, this longer-than-normal article is appearing in The Bulletin.For the complete version of this article, please contact the Division Surgeon: COL Ralph Morris.)

member nevertheless retains the right to immediate reinstatement of the coverage upon returning to the civilian job. However, coverage does not extend to an injury, illness or disease determined by the Secretary of Veterans Affairs to have been incurred or aggravated during military service. If unable to report back to his or her civilian employer because of a service-connected injury, illness or disease, a Reserve member retains the right to reemployment for up to two years (may be extended), but may not have civilian health care reinstated until reporting back to the civilian employer.

In conjunction with the authorities in title 10 governing military health care for both the member and his dependents, USERRA provides a safety net. But that safety net still has some holes. The first problem that may arise is the loss of medical coverage for the member and his dependents if the period required for recovery from an injury, illness or disease incurred while performing inactive duty training extends beyond 18 months. Even if the member elects to extend his civilian medical coverage under USERRA he and his family would be without coverage after 18 months. The second problem relates to the potential cost of maintaining an employer sponsored health plan. Many reservists do not live close to a military medical treatment facility. They must depend on civilian health care. The cost of maintaining a civilian-sponsored health plan may be prohibitive if the member is required to pay the entire premium for maintaining that coverage. This could make continuing civilian coverage problematic for a Reserve component member.

DOD Summit on Reserve Component Health Cape

To fully address the requirements contained in section 746 of the National Defense Authorization Act for or FY 1997, the Department established the DOD Reserve Health Care Summit. One of the principal objectives of the DOD summit was to ensure that those who become ill or injured as a result of military service receive appropriate health care and medical benefits. The summit intended to dispel any lingering disparity in benefits based on length of duty by establishing as a basic premise that "the performance of duty, not the length or type of duty determines a service member's risk and exposure to harm." This proposition recognizes that Reserve component members now work side by side with Active component members performing many of the same missions and accepting comparable risks.

The summit concluded that basing benefits on length of duty or duty status creates a disparity in benefits for Reserve component members. Even though an injury, illness, or disease was incurred or aggravated while performing duty, the benefits a member is entitled to could be different depending on the length of the duty. Military members serving on active duty for 31 days or more, not only receive treatment for any injury, illness, or disease sustained, but are also entitled to comprehensive health care for themselves and their dependents for any other medical conditions that may arise. Reserve component members who are not continued on active duty beyond 30 days after sustaining an injury, or who sustained the injury while performing inactive duty training, may be entitled to treatment for the condition, but are not covered for any other unrelated health care problems that may arise for the member or the member's family. The DOD summit on Reserve component healthcare attempted to address these discrepancies.

Interpreting Statutory Language

The summit determined that certain inconsistencies in authorized medical care or treatment for Reserve component member's stem from varying interpretations of the terminology contained in applicable provisions of law. The piecemeal nature of many of the amendments to section 1074a over the years has contributed to this result. The intent of specific language may not be entirely clear, which can lead to inequities for many Reserve component members.

For example: Is a Reserve component member who sustains an injury after stopping to pick up a child at the day care center while returning from inactive duty training considered to be injured while traveling "directly" from the place of duty? In establishing a comparable standard of reasonableness for veterans benefits, title 38, U.S.C. provides for taking into account such factors as the hours of travel involved, the method of travel employed, the itinerary, and the manner in which the travel was performed. No comparable standard has been provided for disabilities incurred during travel under applicable title 10 U.S.C. provisions.

Other examples include is a member remaining overnight between successive training periods covered if involved in an automobile accident while driving to dinner of f base? Clearly, the member was not in a duty status: however, the member was between successive inactive duty training periods. Although 1985 legislation which provided medical care for aggravation of pre-existing disease was termed the "heart attack" provision, is a member covered if underlying atherosclerosis existed long before any possible aggravation resulting from training duty? The summit determined that these questions of interpretation and those in other situations arise from a lack of specificity in the law and DOD regulations.

Protecting Members on Inactive Duty for Training

The National Defense Authorization Act for FY 1998 provided the authority to modify or extend the orders of a Reserve component member, who is disabled in the line of duty while serving on orders to active duty of 30 days or less. If the extension, which covers the period of treatment or recovery, results in the modified Orders exceeding 30 days, the Reserve component member would become entitled to the same medical and Dental care as an Active component member. He or she would also be entitled to any other benefits that
Relate to active duty status.

Approximately 1,100 Reserve component members become incapacitated each year. About 15% of these cases occur while the member is in an inactive duty training status. Currently these members receive treatment only for the service-related injury, illness or disease. The total cost of this limited health care is about $100,000 per year. It is estimated that placing these incapacitated Reserve members on active duty to provide them with full benefits during the period of treatment and recovery would cost an additional $200,000 per year. This cost takes into consideration the amount of time the member will be incapacitated and the probability that the member has or will be able to continue other health insurance.

There is an average of 2.2 dependents per Reserve component member. Currently, the dependents of Reserve members who are incapacitated while serving on inactive duty for training are not entitled to medical care under the military healthcare system. Placing the incapacitated Reserve member on active duty during treatment and recovery would result in an additional DOD) expense of approximately $500,000 per year to cover the estimated cost of providing health care for their dependents. The summit recommends that Reserve and Guard members on inactive duty for training and their dependents be provided full medical protection and other active duty benefits during the period they are being treated for or are recovering from a service-incurred or aggravated injury, illness or disease.

Reserve Component Dental Care

A large number of Guardsmen and Reservists mobilized during the Persian Gulf War did not meet the dental readiness standards required for deployment. Reportedly, as many as one-quarter of those mobilized could not be deployed until they completed dental examinations and associated treatment. The effort to meet these dental requirements placed considerable strain on mobilization facilities and the military dental care system. Concern for maintaining dental readiness in the Reserve forces, prompted Congress, in the National Defense
Authorization Act for FY 1996, to direct the Department to establish a dental insurance program for members of the Selected Reserve.

The TRICARE Selected Reserve dental Program (TSRDP), authorized by section 1076(b) of title 10, U.S.C., has been in effect since October 1997. To enroll in the program, a Reservist must have at least one-year remaining of his or her commitment to serve in the Selected Reserve. While an estimated 640,000 Reserve members are eligible for the program, enrollment, as of March 1999, is about 27,000 National Guard and Reserve members, considerably lower than the 200,000 initially projected. These initial projections were based on survey data indicating that nearly one-third of all Reservists and Guardsmen had no civilian dental insurance.

The Department is continuing its extensive efforts to increase awareness of TSRDP and thereby increase enrollment in the program. A quick survey and focus groups, conducted to determine the reasons for low enrollment, identified several concerns that may limit Reserve component member participation in the program. Concerns with the current program include the limited provider network; the lack of a family member option and the reduced benefits compared to comparable private sector dental programs.

RESERVE COMPONENT FORCE HEALTH PROTECTION

Historical Perspective

The Persian Gulf War was the first use of the President's involuntary call-up authority, under which nearly 270,000 Reserve component members were mobilized and served an average of nearly six months active duty. The Persian Gulf War highlighted both successes and failures with respect to providing force protection. Despite few casualties, the Department was not adequately prepared to deal with health issues that arose upon completion of the conflict. The difficulty in addressing the health-related problems of many Gulf War veterans, including a large number of reservists, was compounded by the lack of pre and post-deployment medical assessment data collected and maintained on deploying members.

Another watershed event occurred with the call-up of several thousand Reservists possessing skills predominantly resident in the RC to support an operational commitment in Haiti. This reflected the first use of the President's involuntary call-up authority to support a relatively small-scale contingency operation. Limited scale call-ups continued for operations in Bosnia. Roughly 20,000 Reservists have now served an average of 8 to 9 months in support of these operations since December 1995.

Force Health Protection

DOD is developing a force health protection strategy for members who are subject to deployment. That strategy ensures physical fitness, continued health, and medical treatment at the right time and right location so that national objectives and military missions can be achieved. It is designed to benefit the Total Force and to support Joint Vision 2010. Force health protection provides a conceptual framework for optimizing health readiness and protecting service members from all health and environmental hazards associated with military service.

Medical and dental readiness and health promotion are key elements of this comprehensive management strategy. Also important to improving force health protection are the provision of better health information, more effective medical record keeping and a robust health surveillance system. Joint medical surveillance policy establishes the Department's continuous responsibility to provide force health protection to all service members who are subject to deployment, who are deployed or who have completed a deployment. This policy ensures the collection, monitoring and assessment of information relating to the health status, health risks, and health consequences of deployments on individual service members and the military force as a whole.

Deployment health surveillance includes identifying the population at risk, recognizing and assessing hazardous exposures, employing specific countermeasures and monitoring health outcomes. Policies for the health surveillance of Reserve component members must be consistent with the policies established for the Active component. Medical information management is dependent upon an effective medical tracking system for retaining health and health-related data on all military members throughout their military service, and especially before, during and after deployments.

The Department is committed to improving its ability to assess and protect the health of military personnel during deployments. The health status, physical readiness and deployability of Reserve component members ordered to active duty during Operation Desert Storm were a subject of debate. While successful in supporting the overall military effort, mobilization operations revealed that some Reserve component personnel were not in proper medical or physical condition to deploy and perform wartime tasks.

Tracking RC Dental Readiness

The majority of Reserve component members receive their care from civilian dentists. However, information related to such care is not available to the Department. Currently, there is no means established to document the civilian dental care received by Reserve component members. For this reason, the Reserve components do not have an up-to-date status on the dental readiness of all their members. Moreover, if a military dental provider identifies a dental problem, the member is often instructed to seek civilian dental care within a specified period of time. However, mechanisms for monitoring compliance with such instructions are limited. Also, it should be noted that Reservists in low-income families might find it cost prohibitive to seek treatment from a civilian provider, if they lack personal or employer-sponsored dental insurance.

Just as in the case of their physical condition, RC members have a personal obligation to maintain a dental health status that does not preclude their mobilization and deployment. For the most part, the Department considers deployability a condition for or retaining a member in the Reserve components. However, to enforce the requirement for members to maintain their dental health as a condition of retention, there must be a mechanism for RC commanders to track and record the dental readiness of unit members.

CONCLUSION

Today the Reserve components are integrated into the total force and operate in conjunction with the Active force to support virtually all operations. The annual level of support provided over each of the past three years equates to about 1/3 the level of support provided by the Reserve components during the peak of Operation Desert Storm. To function in this more demanding, post-Cold War environment, National Guard and Reserve members must meet the same standards for physical condition and readiness as their Active counterparts.

Clearly, DOD has evolved from a Reserve component focused on training for mobilization to a Reserve component that is operationally relevant on a day-to-day basis. While Guard and Reserve members serve part-time, they maintain a full-time military commitment. They are available for immediate call to active duty. The recommendations contained in this report and listed separately below recognize the need to reassess the requirements for or healthcare and medical readiness to ensure equitable protection for or our Reserve component “full-time part-timers” in the event of service-incurred or aggravated injury, illness or disease, and health and environmental hazards associated with deployment or other military service.

RECOMMENDATIONS

1. Establish definitions in low or DOD regulation to describe specifically what constitutes “incurring” or “aggravating” an injury, illness or disease in the “line of duty.”

2. Allow DOD to place a Reserve component member who is injured, becomes ill or contracts disease in the line of duty while performing inactive duty training, on active duty during the period of treatment for or recovery from the injury, illness or disease.

3. Allow DOD to provide medical coverage for Reserve component members who become injured or ill while remaining overnight at the site of inactive duty training between successive training periods, even if they reside within a reasonable commuting distance.

4. Provide permanent statutory authority for the Secretary of Defense to waive or reduce CHAMPUS (TRICARE) annual deductible amounts (currently $300 per family) in the case of dependents of Reserve component members ordered to active duty for less than one year in support of a contingency operation.

5. Authorize an expanded TRICARE dental program that provides for merging the Selected Reserve Dental Program into the Family Member Dental Program thereby ensuring a more comprehensive benefits package for Reserve component members and a family member option at no cost to the government.

6. Conduct a study designed to determine the overall medical readiness of Reserve component members in order to determine prospectively their fitness for duty as well as boo’s ability to monitor and access such information.

7. Conduct a phased study, in conjunction with Recommendation 6 above, too:

    1. Identify potential health risks or problems that have a direct impact on deployability and retention of RC members;

    2. Develop a more cost effective, focused health assessment tool for use in conducting physical exams for RC members;

3. Establish a pilot program to measure individual medical fitness and deployability;

4. Establish joint procedures, based on the results of the pilot program that will ensure greater consistency and uniformity in determining the medical readiness of Reserve component members.

8. Amend section 10206 of title 10, United States Code, to eliminate any physical examination requirement for members of the IRR prior to activation, if not previously examined during activation within the post five years. Develop a more effective annual physical condition certification questionnaire for IRR members of all the Services.

9. Eliminate sections 1074a(d), to include the requirement for preferential dental care for Army early deployers. Identify a more efficient and cost-effective health assessment program for ensuring the medical readiness of early-deploying PC members.

10. Identify cost-effective alternatives for accomplishing medical readiness requirements that consider the use of other facilities, including those of the Department of Veterans Affairs, Health and Human Services, civilian contractors or private practitioners. DOD should continue to pursue ongoing efforts to establish memorandums of agreement with Veterans Affairs and Federal Occupational Health.

11. Develop and implement a standardized dental examination and classification form that can be completed by a military or a civilian dentist and that will satisfy the DOD annual dental examination and classification requirement. Establish the technical electronic support necessary to track dental classification and treatment compliance and to incorporate tracking information into existing automated information systems while ensuring that this information is easily accessible to RC unit commanders.

12. Develop a more comprehensive approach to administration of immunizations for the Reserve components that includes maximum cost-effective use of other federal agencies and civilian facilities. Develop Reserve component requirements for existing and proposed Total Force automated tracking systems to monitor the immunization readiness of Reserve component members and to ensure commanders have immediate access to the health readiness status of their unit personnel.

13. Optical readiness should be considered a Total Force health protection measure with protective mask insert (PMI) requirements identified and funded in peacetime for the Total Force. Force health protection measures, including the purchase of spectacles and PMI's should not be resourced from training funds. A mechanism should be established for members to reimburse the Department for the negligent loss of PMI.

14. Ensure all RC members are made aware of their rights and responsibilities with respect to their medical and dental readiness and that they are held accountable for meeting retention and deployment standards. Determine the most cost-effective and efficient methods to achieve Reserve component force health protection measures and provide adequate funding.

The recommendations contained in this report have not been subjected to program analysis and evaluation by the Department nor evaluated under the Planning, Programming and Budgeting review process of the Department of Defense. Any legislative proposals that DOD develops pursuant to this report are subject to review by the Office of Management and Budget.

Message From The Chief:

The Secretary of the Army and the Chief of Staff have addressed the issue of the Army's policy on homosexuality in a recent message to the field, an excerpt follows:

"Service in our Army is honorable and respected by the citizens of this country. Soldiers who offer their commitment and their lives in this service should and must be treated with dignity, honor and respect. Respect for our fellow soldiers demands that we speak with respect for all. Any derogatory words about any group, including those based upoon sexual orientation, that are prejudicial to good order and discipline, may subject the soldier to adverse administrative actions or disciplinary measures under the UCMJ. Every soldier has the right to expect treatment consistent with our core values, a safe and secure environment, and the support of their chain of command. Whenever we violate the trust of any soldier, we violate the trust of all soldiers.

We affirm that treating soldiers with dignity and respect is a bedrock value for the Army. We declare that there is no room for harassment or threats to any soldier in our Army for any reason. Therefore, as the senior leaders of the Army, we are determined to continue to implement the 'don't ask, don't tell' policy with equity and fairness to all of our soldiers."

(Reprinted from Soldiers Magazine, Feb. 2000 issue)

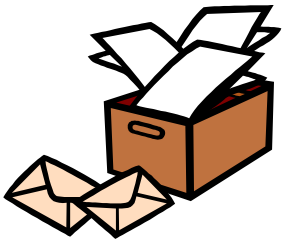
Send Us Your News

The Public Affairs Office is requesting from all Brigades, G-Staffs, and Special Staffs, current section information for the division newsletter.

Information may include training exercises, new personnel, family support functions, or any other information you want the division to know about.

This information may be submitted on a 3X5 disk in MSWord format, along with a printed copy or by email to the Public Affairs Officer at hrmeneely@yahoo.com.

Snail mail address: 1850 Old Spanish Trail, Public Affairs Office, Houston, TX 77054. The PAO may be reached by telephone at 713-799-7909.



Message continued from Col. 1

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